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No. 89-939

In The

Supreme Court of the United States

October Term, 1989

HEALTHAMERICA AND PAMELA MERLE,

Petitioners,

v.

EDWARD MENTON,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF ALABAMA

RESPONDENT'S BRIEF IN OPPOSITION

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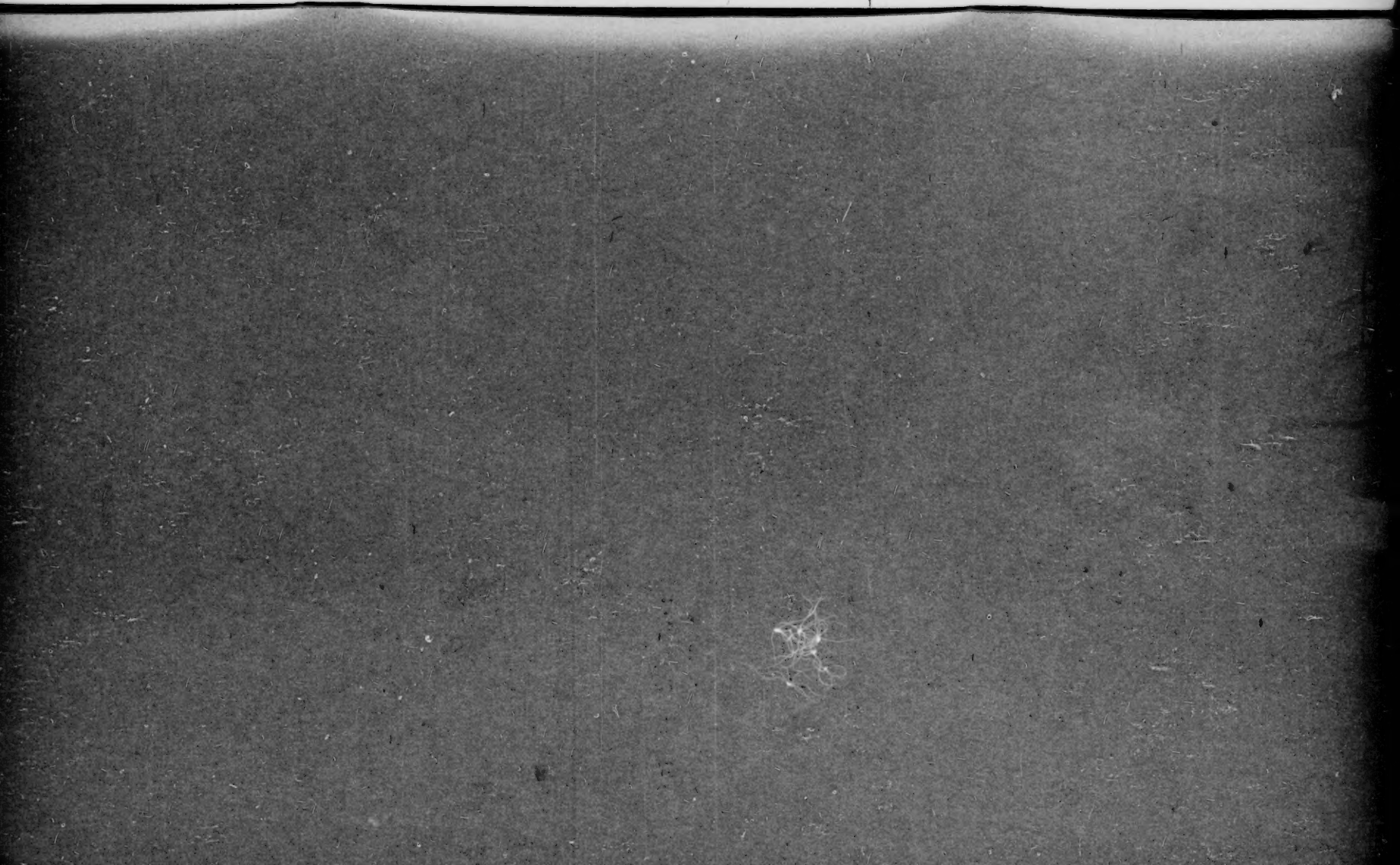

QUESTIONS PRESENTED

1. Whether a state common law action for fraud "relates to" an employee benefit plan within the meaning of ERISA's preemption clause where the plaintiff alleges that the defendants fraudulently induced him to drop his existing medical insurance and to join defendants' health plan?

2. Whether an Alabama insurance trade practices law, which prohibits any person from making false or misleading representations to induce policyholders to drop or change insurance coverage, is a law which "regulates insurance" within the meaning of ERISA's savings clause?

3. Whether a punitive damage award of $1,797,588.00 for reprehensible, fraudulent conduct, which personally exposed the respondent to potentially "hundreds of thousands of dollars" of unexpected medical bills, violates the Due Process Clause of the Fourteenth Amendment, where the amount of the award was subject to an "extensive post-trial evidentiary hearing", and to searching *de novo* review by both the trial and appellate courts?

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RESPONDENT'S BRIEF IN OPPOSITION

STATEMENT OF THE CASE

As set forth in the July 21, 1989 Opinion of the Alabama Supreme Court (hereinafter "Opinion"), respondent, Edward Menton, was employed as city editor for the *Mobile Press Register* newspaper ("Press Register"). As part of his employment, Mr. Menton was provided medical insurance coverage through the Connecticut General Insurance Company ("Connecticut General"). The Press Register paid 50-60% of the premiums for this insurance and the balance was deducted from Mr. Menton's salary.

Mr. Menton had a son, Jacob, who suffered from a form of cerebral palsy which affected his ability to walk.

To walk normally, Jacob required regular physical therapy treatments, leg braces, crutches, walkers, and other orthopaedic appliances. Pursuant to its policy, Connecticut General paid eighty percent of the costs for Jacob's surgeries, physical therapy, and orthopaedic appliances.

In June, 1985 the Press Register announced "an alternative medical benefit selection", which allowed qualified employees either to keep the Connecticut General insurance or to enroll in one of two health maintenance organizations, Prime Health and petitioner, HealthAmerica. The announcement stated: "Prime Health, Health America [sic] and Connecticut General will be offered to you as a multiple choice option; permitting each employee to continue his or her current health benefits program or to select either of the HMOs for your health care needs." Qualified employees could elect to change coverage during the month of June, 1985 without suffering an interruption of benefits.

With the assistance of David Parker, the assistant general manager of the Press Register, HealthAmerica and Prime Health distributed information about their plans, including a summary of benefits, to the Press Register employees. Because HealthAmerica's list of health care providers included both of Jacob's physicians, Mr. Menton considered joining HealthAmerica's plan, *if HealthAmerica's coverage of Jacob's medical and therapeutic expenses was better than Connecticut General's.* The summary of benefits, however, did not indicate whether HealthAmerica provided coverage for long-term physical therapy and orthopaedic appliances.

Mr. Menton asked Parker whether HealthAmerica provided coverage for Jacob's medical and therapeutic

expenses. Parker could not answer Mr. Menton's question, but suggested that Mr. Menton ask the HealthAmerica representative who was scheduled to hold an informational presentation at the Press Register. The purpose of the presentation was to enable both HealthAmerica and Prime Health "to specifically outline their plan[s]" and to answer specific questions from Press Register employees about coverage. Petitioner, Pamela Merle, presided over this meeting on behalf of HealthAmerica.

Mr. Menton attended Merle's presentation for the sole purpose of determining whether HealthAmerica's plan provided more than eighty percent coverage for Jacob's medical and therapeutic expenses. During the presentation, Press Register employees were repeatedly told that the coverage provided by HealthAmerica and Prime Health was "the same or better" than the Connecticut General coverage. In addition, HealthAmerica distributed a pamphlet which stated that HealthAmerica's plan provided "[m]ore benefits, fewer limitations and no financial surprises" and had "generally no time or dollar limits on coverage".

After the presentation, Mr. Menton asked Merle specific questions about HealthAmerica's coverage of Jacob's medical and therapeutic expenses. He explained Jacob's medical history and his need for extensive, long-term physical therapy and orthopaedic appliances. In response to a direct question from Mr. Menton, Merle informed Mr. Menton that Jacob's medical and therapeutic expenses would be "covered 100% by HealthAmerica." Merle gave no suggestion or hint that physical therapy benefits would be limited in any way.

In reliance upon Merle's representations, Mr. Menton dropped his Connecticut General coverage and enrolled

in HealthAmerica's plan. After enrolling, Mr. Menton received a schedule of benefits in the mail. On reviewing the schedule, Mr. Menton noticed that "short-term" outpatient services for physical therapy were apparently covered for only two months and none of the expenses for Jacob's crutches, braces and walker were covered. At the suggestion of David Parker, who witnessed Merle's representations at the informational meeting, Mr. Menton contacted Merle about the meaning of the limitation contained in the schedule of benefits. Merle told Mr. Menton that HealthAmerica's plan indeed covered only two months of Jacob's physical therapy and *none* of the expenses for orthopaedic appliances. Merle also admitted to Mr. Menton that she had misrepresented the coverage.

Thereafter, Mr. Menton attempted to get HealthAmerica to provide the coverage he had been promised when he dropped his Connecticut General insurance. Mr. Menton was told that his problem would have to be presented to a board of doctors to determine whether the physical therapy benefits could be extended. After several months and numerous dealings, HealthAmerica eventually offered to extend coverage for Jacob's physical therapy for an additional sixty days, but refused to provide coverage beyond that because Mr. Menton's claim was "outside [the] benefit plan" and "could certainly involve hundreds of thousands of dollars . . . ." Even with the extension,[1] HealthAmerica intentionally exposed Mr. Menton to potentially "hundreds of thousands of dollars" of uncovered medical bills and gave no thought to the fact that Jacob might be deprived of needed treatment as a result.

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[1] HealthAmerica never paid any of the bills incurred during the additional sixty day period.

Despite Merle's previous admission, petitioners steadfastly denied that Merle misrepresented the coverage to Mr. Menton. It was later revealed that Merle had confessed making the misrepresentation during an internal investigation of Mr. Menton's claim. At the subsequent trial, the jury quite clearly concluded that petitioners lied to Mr. Menton during his attempts to resolve the matter and that Merle and HealthAmerica's executive vice president testified falsely under oath.

Mr. Menton filed the instant action against petitioners alleging a state common law action for fraudulent misrepresentation, asserting that petitioners willfully or recklessly induced him to drop his Connecticut General insurance and to elect the petitioners' coverage. Petitioners did not seek to remove this action to federal district court on the basis of ERISA, nor did they allege the failure to exhaust grievance procedures under HealthAmerica's plan as a defense. Instead, petitioners pleaded the general issue and, by amended answer filed *two days* before trial and motion for summary judgment filed barely *a month* before trial, preemption by the Employee Retirement Income Security Act of 1974 ("ERISA"). 29 U.S.C. §§ 1001 *et seq.*

The trial court determined that Mr. Menton's claim was "saved" from preemption by the Alabama "twisting" statute, Ala. Code § 27-12-6, an Alabama Insurance Trade Practices Law which expressly forbids the petitioners' conduct. See, Pet. at 63a. The trial court submitted the case to the jury with instructions on Alabama civil actions for misrepresentation, without reference to the twisting statute. The jury returned a verdict in favor of Mr. Menton. After final judgment, Mr. Menton filed a motion to amend his complaint to conform to the evidence, alleging

a violation of Ala. Code § 27-12-6, i.e., the "twisting" statute. Petitioners' objection to this was overruled, as was their motion for a judgment notwithstanding the verdict and new trial.

On appeal, the Alabama Supreme Court affirmed the judgment of the trial court. The Alabama Supreme Court held that Mr. Menton's fraud action does not "relate to" a benefit plan within the meaning of ERISA's preemption clause. Opinion, Pet. at 8a-15a. The court also held that Mr. Menton's claim is excepted from preemption by ERISA's insurance savings clause because his claim was based upon a state law, the twisting statute, which "regulates insurance". Pet. at 16a. The Alabama Supreme Court refused to review petitioners' constitutional challenges because such issues were not timely raised in the trial court. Pet. at 25a. Following the Alabama Supreme Court's denial of their application for rehearing, petitioners sought a stay of the judgment from Circuit Justice Kennedy, who granted the stay on October 3, 1989 pending this Court's action on the instant petition.

SUMMARY OF ARGUMENT

The Alabama Supreme Court's opinion involves the dual interpretation of ERISA's preemption and savings clauses. Both aspects of the court's opinion are fully consistent with this Court's ERISA decisions. While decisions rendered by the Ninth and Eleventh Circuits conflict with the Alabama Supreme Court's opinion with respect to ERISA preemption, these decisions do not conflict with that portion of the court's opinion which concerns ERISA's savings clause. Hence, the decisions rendered by the Ninth and Eleventh Circuits do not wholly conflict with the court's opinion.

With regard to the court's holding that the twisting statute is saved from ERISA preemption, the court's opinion appears on its surface to conflict with a decision rendered by the Fourth Circuit Court of Appeals. The Fourth Circuit held that a state trade practices law does not "regulate insurance". However, a closer examination reveals that the Fourth Circuit failed to consider this Court's previous ERISA and McCarran-Ferguson decisions which plainly establish that state trade practices laws are indeed laws which "regulate insurance". The stated purpose of Alabama's twisting statute is to "regulate trade practices in the business of insurance". Since the Alabama Supreme Court's decision on the "savings" issue is consistent with this Court's previous decisions, this Court need not grant review to decide this issue.

Petitioners failed to timely raise both the due process challenges and the potential applicability of ERISA's fiduciary and disclosure requirement in the courts below. Consequently, neither of the courts below considered or resolved these issues. Due to the absence of a properly developed record with respect to these important issues, this Court should deny review.

REASONS FOR DENYING THE WRIT

I. THIS COURT SHOULD NOT GRANT REVIEW TO DECIDE WHETHER ERISA PREEMPTS A CLAIM FOR FRAUDULENTLY INDUCING AN EMPLOYEE TO CHANGE HIS HEALTH COVERAGE.

The Alabama Supreme Court's decision is entirely consistent with the decisions of this Court. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), this Court, in an unanimous decision, observed that laws

which regulate the manner in which insurance is sold do not "relate to" benefit plans:

> "Appellants assert that state laws that directly regulate the insurer, and laws that regulate such matters as the way in which insurance may be sold, are traditional laws subject to the [savings] clause, while laws that regulate the substantive terms of insurance contracts are recent innovations more properly seen as health laws rather than as insurance laws, which § 514(b)(2)(A) does not save. *This distinction reads the savings clause out of ERISA entirely, because laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans in the first instance.* Because they would not be preempted by § 514(a), they do not need to be 'saved' by § 514(b)(2)(A) . . . Appellants' construction, in our view, violates the plain meaning of the statutory language and renders redundant both the savings clause it is construing, as well as the deemer clause which proceeds it, and accordingly has little to recommend it."

Id. at 741. Because Mr. Menton's action was based on the twisting statute (see, Pet. at 63a), which specifically regulates the activities of insurance companies in selling insurance and the activities of other entities offering policyholders an alternative to insurance, Mr. Menton's claim does not "relate to" HealthAmerica's plan in the first instance. Thus, the Alabama Supreme Court's decision is consistent with the plain holding of this Court in *Metropolitan Life.*

Despite petitioners' assertion to the contrary (Pet. at 10-11), the Alabama Supreme Court correctly concluded that this Court did not address this issue in *Pilot Life Ins.*

Co. v. Dedeaux, 481 U.S. 41 (1987).[2] In fact, this Court expressly noted that there was "no dispute" that Dedeaux's claims were embraced by ERISA's preemption clause; the only dispute concerned whether his claims were "saved" from preemption. *Id.* at 47. Since *Pilot Life* does not address an action alleging fraudulent inducement *to join an employee benefit plan*, the Alabama Supreme Court's decision is hardly inconsistent therewith.

It is extremely important to note that the basis of Mr. Menton's action concerns the fact that petitioners fraudulently *induced* him to drop his health insurance and opt for HealthAmerica's plan. Opinion, Pet at 8a. Mr. Menton's action, therefore, concerns matters *external* to HealthAmerica's plan and acts *preliminary* to his joining the plan. His action claims damages for being ***induced*** to drop his Connecticut General coverage. It is for this reason, as petitioners so correctly pointed out in the court below, that Mr. Menton's actual damages are calculated by reference to the benefits he would have received if he had kept his Connecticut General coverage. In other words, Mr. Menton's claim concerns the destruction of his old plan, not the confection of the new. For this reason, Mr. Menton's fraud action does not "relate to" HealthAmerica's plan. Opinion, Pet. at 6a.

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[2] The Alabama Supreme Court noted: "Although the complaint in *Pilot Life* contained a count for 'fraud in the inducement', the opinion makes it unmistakably clear that the only claims [Dedeaux] pursued were claims seeking damages for improperly processing his claims for benefits under an ERISA-regulated plan." Opinion, Pet. at 7a.

Petitioners assert that Mr. Menton's fraud action "is concerned with and arises out of the *administration* of an ongoing ERISA benefit plan" and that Merle's misrepresentation "occurred during the process of *explaining coverage and options* under an existing welfare benefit plan". Pet. at 10 & 13 (emphasis added). These assertions clearly mischaracterize the nature of petitioners' conduct. Petitioners were not engaged in the "administration" of an employee benefit plan and were not "explaining coverage and options". Rather, petitioners were engaged in the *solicitation* of membership for their plan. Merle's very purpose for being at the Press Register was to induce employees to drop their existing medical insurance in favor of HealthAmerica's purportedly better, less expensive medical plan.[3]

In reaching its decision, the Alabama Supreme Court relied upon the Court's holding in *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987), which was decided two months after *Pilot Life*. Opinion, Pet. at 8a-9a. In *Fort Halifax*, the Court held that a Maine statute requiring employers to make one-time severance payments to employees when a plant closed was not preempted by ERISA. The Court noted that the preemption clause expressly states that state laws are superseded to the extent they "relate to any employee benefit plan." The Court stated that the preemption clause "does not refer to state laws relating to 'employee benefits', but to state laws relating to 'employee benefit *plans*.' " *Id.* at 7 (emphasis in original). "Given the basic difference

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[3] These activities are subject to substantial state regulation which is expressly saved from preemption. See Argument II, infra.

between a 'benefit' and a 'plan', Congress' choice of language is significant in its pre-emption of only the latter." *Id.* at 8. The Alabama Supreme Court concluded that the distinction drawn by this Court between laws which relate to employee benefit *plans* and laws which simply relate to employee *benefits* precludes the preemption of Mr. Menton's fraud action. Opinion at 9a. At best, Mr. Menton's action concerns only employee benefits – and then only to the extent that benefits were the inducement falsely offered to secure his membership – not to the plan itself.

The Alabama Supreme Court's opinion on this issue is consistent with the decisions of the Fifth and Sixth Circuit Courts of Appeals, the Michigan Supreme Court, and several federal district courts. *Wells v. General Motors Corp.*, 881 F.2d 166 (5th Cir. 1989)(action based upon false inducements to opt for different plan, *held* not preempted); *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989)(fraudulent inducement to participate in plan, *held* not preempted); *Teper v. Park West Galleries, Inc.*, 431 Mich. 202, 427 N.W.2d 535 (1988)(breach of oral assurances for lifetime employment, *held* not preempted); *Butler v. Fringe Benefits Plan, Inc.*, 701 F. Supp. 804 (N.D. Ala. 1988)(fraudulent inducement to switch plans and violation of Alabama twisting statute, *held* not preempted); *McNamee v. Bethlehem Steel Corp.*, 692 F. Supp. 1477 (E.D.N.Y. 1988)(misrepresentation of pension benefits to induce reemployment, *held* not preempted); *Quigley v. Unum Life Ins. Co.*, 688 F. Supp. 80 (D. Mass. 1988); *Greenblatt v. The Budd Co.*, 666 F. Supp. 735 (E.D. Pa. 1987)(misrepresentation that pension benefits under new plan equal benefits under old plan, *held* not preempted); *Morningstar v. Meijer, Inc.*, 662 F. Supp. 555 (E.D. Mich.

1987)(breach of employment contract). Several of these courts relied heavily upon this Court's decision in *Fort Halifax* in finding no preemption.

Petitioners contend (Pet. at 10 & 12) that the decisions of ten federal courts conflict with the Alabama Supreme Court's decision. However, only two of the decisions cited by petitioners, *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989) and *Davidian v. Southern Cal. Meat Cutters Union*, 859 F.2d 134 (9th Cir. 1988), actually conflict, and these two cases did not consider this Court's important distinction between employee *benefits* and employee benefit *plans* as discussed in *Fort Halifax*. The eight remaining cases do not deal with claims asserting fraudulent inducement to *join* a plan.[4] Hence, the Alabama Supreme Court's decision on this issue actually conflicts with only the Ninth and Eleventh Circuits in

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[4] Two of the cases alleged misrepresentation of coverage for hospital admittance. These misrepresentations occurred well after the employees had been participants in the plans. *Hermann Hosp. v. MEBA Medical & Benefits Plan*, 845 F.2d 1286, 1287 (5th Cir. 1988) and *Comprehensive Care Corp. v. Doughtry*, 682 F. Supp. 516, 517 (S.D. Fla. 1988). The five remaining cases mention the word "fraud", but the claims did not involve fraudulent inducement to join a plan. *Johnson v. District 2 Marine Eng. Beneficial Ass'n*, 857 F.2d 514 (9th Cir. 1988); *Straub v. Western Union Tele. Co.*, 851 F.2d 1262 (10th Cir. 1988); *Reilly v. Blue Cross & Blue Shield of Wis.*, 846 F.2d 416 (7th Cir. 1988); *Phillips v. Amoco Oil Co.*, 799 F.2d 1464 (11th Cir. 1986); *Tucker v. Employers Life Ins. Co.*, 689 F. Supp. 1073 (N.D. Ala. 1988). Although petitioners assert (Pet. at 11) that the complaint in *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987), alleged fraudulent inducement, the court's opinion makes no reference to fraudulent inducement to join the plan.

Farlow and *Davidian*. However, because neither *Farlow* nor *Davidian* deals with the second part of the Alabama Supreme Court's decision concerning the savings clause,[5] it cannot be said that these cases fully conflict with the Alabama Supreme Court's holding. Because the whole of the Alabama Supreme Court's decision does not conflict with the decisions of any federal circuit court, there exists no "special and important reasons" for granting the instant petition. S. Ct. R. 17.

II. THIS COURT SHOULD NOT GRANT REVIEW TO DECIDE WHETHER A STATE INSURANCE TRADE PRACTICES LAW "REGULATES INSURANCE" WITHIN THE MEANING OF ERISA'S SAVINGS CLAUSE

In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), this Court noted that ERISA's preemption clause is "substantially qualified by an 'insurance savings clause,' . . . which *broadly* states that, with one exception, nothing in ERISA 'shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.' " *Id.* at 733 (emphasis added)(citation omitted). The Court noted that ERISA's insurance savings clause saves "an entire body of law from the sweeping general pre-emption clause". *Id.* at 745 n.23. In discussing the various types of state insurance regulation, this Court specifically noted: "Group insurance is presently subject to extensive state regulation,

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[5] While an action under Alabama's twisting statute was raised in *Farlow*, the Eleventh Circuit never reached this issue: "Because we conclude that the twisting statute does not create a private cause of action, we do not address whether ERISA preempts this claim." 874 F.2d at 795 n.3.

including regulation of the carrier, regulation of the *sale and advertising of the insurance*, and regulation of the content of the contracts." *Id.* at 727-28 (emphasis added).

This Court further recognized that Congress designed the ERISA savings clause to preserve the McCarran-Ferguson Act's reservation of the regulation of the business of insurance to the states.[6] Therefore, as aptly stated by petitioners (Pet. at 20), "a Court must consider the case law interpreting the phrase 'business of insurance' under the McCarran-Ferguson Act" in deciding which state laws "regulate insurance" for the purpose of ERISA's savings clause. Pet. at 20 (citing *Pilot Life v. Dedeaux*).

In *FTC v. National Cas. Co.*, 357 U.S. 560 (1958), this Court held that the in-person solicitation of insurance by agents of an insurance company constituted the "business of insurance" within the meaning of the McCarran-Ferguson Act and was subject to state unfair trade practices laws prescribing unfair insurance advertising. *Id.* at 564.[7] In its opinion, this Court specifically noted that thirty-six states had enacted the "Model Unfair Trade Practices Bill". *Id.* at 565 n.6. Alabama's "Trade Practices Law",

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[6] "The ERISA savings clause, with its similarly worded protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The savings clause in the McCarran-Ferguson Act served the same federal policy and utilized similar language to define what is left to the States." *Metropolitan Life*, 471 U.S. at 744 n.21.

[7] *See, also, SEC v. National Sec., Inc.*, 393 U.S. 453, 460 (1969)("selling and advertising of policies" constitutes "business of insurance").

including specifically the "twisting" statute, was adopted from the Model Unfair Trade Practices Bill. Ala. Code § 27-12-1; *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791, 796 (11th Cir. 1989).

Other courts have recognized that "[a]n insurance company's method of *inducing people to become policyholders* pertains to the company-policyholder relationship, and thus constitutes an integral part of the 'business of insurance' ". *Dexter v. Equitable Life Assurance Soc'y of the United States*, 527 F.2d 233, 235 (2nd Cir. 1975)(emphasis added); *see, also, Seasongood v. K & K Ins. Agency*, 414 F. Supp. 698, 701 (E.D. Mo. 1976)(convincing plaintiff to switch his insurance coverage constituted the "business of insurance") *rev'd on other grounds*, 548 F.2d 729 (8th Cir. 1977).

Thus, although petitioners insist (Pet. at 19) that the Alabama Supreme Court erred by not individually analyzing each of the McCarran-Ferguson factors utilized by this Court in *Pilot Life*, an individual analysis of such factors was clearly not necessary. This Court's previous decisions construing the McCarran-Ferguson Act clearly establish that state insurance trade practices laws are indeed laws which "regulate insurance".[8] Accordingly,

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[8] The cases cited by petitioners for the contrary position completely fail to consider the case law construing the McCarran-Ferguson Act. *Rollo v. Maxicare of La., Inc.*, 695 F. Supp. 245, 248 (E.D. La. 1988); *Keel v. Group Hospitalization Med. Serv.*, 695 F. Supp. 223, 227 n.13 (E.D. Va. 1988); *Denette v. Life of Ind. Ins. Co.*, 693 F. Supp. 959, 963-64 (D. Colo. 1988). Although the Fourth Circuit in *Powell v. Chesapeake & Potomac Tel. Co. of Va.*, 780 F.2d 419 (4th Cir. 1985) cites *SEC v. National Sec.*, the court did not consider that aspect of *SEC v. National Sec.* which expressly holds that state trade practices laws regulating the selling and advertising of insurance are within the scope of the McCarran-Ferguson Act. *Powell*, 780 F.2d at 423.

the Alabama Supreme Court correctly held that the twisting statute "regulates insurance". Opinion, Pet. at 18a.[9] This conclusion is supported by the Alabama Legislature's expression of purpose in enacting the Trade Practices Law: "The purpose of this chapter is to regulate trade practices *in the business of insurance* in accordance with the intent of congress as expressed in the [McCarran-Ferguson Act] . . . ." Ala. Code § 27-12-1(a)(emphasis added). Other courts confronted with state laws expressly designed to regulate the insurance business have concluded that civil actions based on those laws were saved from ERISA preemption. *Soniat v. Travelers Ins. Co.*, 538 So. 2d 210, 214-15 (La. 1989); *Locklear v. Visko's, Inc.*, 545 So. 2d 695, 696 (La. App. 1989).

Petitioners claim (Pet. at 19 & 22) that the twisting statute, when applied to HealthAmerica's solicitation activities, does not "regulate insurance" because HealthAmerica is a health maintenance organization, not an insurance company. However, HMO's, by statute, are expressly regulated by Alabama's Trade Practices Law. Ala. Code § 27-21A-13(b). The Alabama Legislature placed the laws governing the organization and operation of HMO's in the Alabama Insurance Code, indicating that

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[9] Petitioners also suggest (Pet. at 19) that the Alabama Supreme Court may have erred in finding a private cause of action under the twisting statute. However, the question of whether a state statute provides a private cause of action is a question of state law. *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989). Moreover, the Alabama Supreme Court has previously held that a violation of the twisting statute supports a cause of action for fraud. *Jarrard v. Nationwide Mut. Ins. Co.*, 495 So. 2d 584, 586 (Ala. 1986).

HMO's are regarded as a form of insurance in Alabama. *See*, Ala. Code §§ 27-21A-1 *et seq*. The fact that the twisting statute applies to HMO's does not diminish its force as a law that regulates the business of insurance, particularly because HMO's compete against insurance companies for membership. The instant case serves as a perfect example of why HMO's are subject to the twisting statute. While an HMO might not meet the classic definition of an insurance company,[10] when an HMO competes for a share of the insurance market, it is subject to laws that "regulate insurance". In other words, the Alabama Supreme Court did not hold that petitioners were engaged in the "business of insurance"; rather, the court found that petitioners' solicitation activities were governed by a state law "regulating insurance". Opinion, Pet. at 18a.

Without specifying how, petitioners also contend that even if Mr. Menton's claim were saved, it would nevertheless be preempted because of its "disruption of ERISA's exclusive civil enforcement scheme". Pet. at 23. First, it bears repeating that Mr. Menton did not seek to enforce or recover any benefits *due under the terms of any plan*. Mr. Menton sought *damages* for the *destruction* of his insurance plan, not benefits under petitioners' plan. All

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[10] Although not determinative of the Alabama Supreme Court's decision, Mr. Menton asserted below that an HMO is functionally indistinguishable from health insurance. *See, Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 237-38 (1979)(Brennan, J. dissenting); *Physicians Health Plan, Inc. v. Citizens Ins. Co. of Am.*, 673 F. Supp. 903 (W.D. Mich. 1987); *West Michigan Health Care Network v. Transamerica Ins. Corp. of Am.*, 167 Mich. App. 218, 421 N.W.2d 638 (1987).

of the remedies enumerated in ERISA's civil enforcement scheme speak of actions to recover benefits, or to enforce or clarify rights to benefits, due "under the terms of the plan." 29 U.S.C. § 1132(a). See, Pet. at 58a-59a.

Second, even if the twisting statute creates disuniformity, which has not been established and is denied, "[s]uch disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985). Congress intentionally saved state laws like the twisting statute from preemption. Thus, application of the twisting statute in this case does not disrupt Congress' intention, but carries out its intention.

III. THIS COURT SHOULD NOT GRANT REVIEW TO DECIDE WHETHER ERISA'S FIDUCIARY AND DISCLOSURE REQUIREMENTS PERTAIN TO THE SOLICITATION OF PLAN MEMBERSHIP

This Court should not grant review to resolve petitioners' proposed fiduciary and disclosure issues for several reasons. First, because Mr. Menton's action is "saved" from preemption by the insurance savings clause, it is expressly not displaced by ERISA's fiduciary and disclosure provisions. As previously noted, Congress substantially qualified the preemptive effect of ERISA by broadly stating in the savings clause that "*nothing* in this subchapter shall be *construed* to exempt or relieve any person from any law of any State which regulates insurance . . . ." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 733 (1985); 29 U.S.C. § 1144(b)(2)(A). With this statement, Congress could not have made its intent any

clearer that *nothing* in ERISA, which includes the fiduciary and disclosure provisions, shall be *construed* to exempt or relieve any person from state laws regulating insurance. Because petitioners' fraudulent conduct was regulated by the Alabama twisting statute, the fiduciary and disclosure requirements cannot be invoked to relieve petitioners of liability.

Second, petitioners' proposed fiduciary and disclosure issues were neither raised in nor resolved by the courts below. Petitioners never sought to remove this case to federal district court on the basis of ERISA, and waited fourteen months after the action had been filed (barely a month before trial) to raise ERISA preemption as a defense. Moreover, petitioners did not so much as suggest in the trial court that ERISA's fiduciary and disclosure provisions might be applicable to this action. Consequently, as petitioners admitted in the court below, "there is little evidence in the record as to Menton's possible ERISA claim against the administrator or fiduciaries of the MPR's employee welfare benefit plan."

Likewise, petitioners did not suggest the potential applicability of the fiduciary and disclosure provisions before the Alabama Supreme Court until the filing of their reply brief. The Alabama Supreme Court does not review issues raised for the first time on appeal. *Stephens v. Central of Ga. R.R. Co.*, 367 So. 2d 192, 194-95 (Ala. 1979). As a result, neither court below made any findings of fact relevant to these issues nor considered or resolved the potential applicability of these provisions.

The difficulty created by the absence of factual findings in resolving these important issues is well illustrated by petitioners' arguments. For example, petitioners assert

that the Press Register "may" have failed to provide Mr. Menton with a sufficient description of HealthAmerica's plan and "may" have failed to make a copy of the plan available (Pet. at 15); that "if" Mr. Menton had made a written request for a complete schedule of benefits and "if" the Press Register had failed to comply, neither of which occurred, the Press Register would have violated a disclosure requirement (Pet. at 15-16); that Merle, *assuming* she was a fiduciary, "may" have breached a fiduciary duty (Pet. at 17); that "if" Mr. Menton failed to pursue formal grievance procedures because of a statement made by a HealthAmerica employee, HealthAmerica "could" be liable for breach of fiduciary duty (Pet. at 17).

Obviously, petitioners' failure to timely raise the fiduciary and disclosure provisions in the courts below has resulted in the total absence of a properly developed record from which this Court might decide these important issues.

> "It is the general rule, of course, that a federal appellate court does not consider an issue not passed upon below . . . . [T]his is 'essential in order that parties may have the opportunity to offer all the evidence they believe relevant to the issues . . . [and] in order that litigants may not be surprised on appeal by final decision there of issues upon which they have had no opportunity to introduce evidence.' "

Singleton v. Wulff, 428 U.S. 106, 120 (1976)(citation omitted); *see, also, Browning-Ferris v. Kelco Disposal*, 106 L.Ed.2d 219, 239 n.23 (1989) (Court declined review due to "the absence of a record on the due process point developed in the District Court and the Court of Appeals"). Petitioners' failure to raise the fiduciary and

disclosure provisions has forced petitioners to argue hypothetical facts, completely remote in some instances from the facts in this case, which, "may" have invoked fiduciary and disclosure obligations "if" they had occurred. This case obviously does not provide this Court with a practical opportunity to review these issues.

Third, the fiduciary and disclosure provisions plainly do not pertain to the *solicitation* of plan membership. Petitioners contend (Pet. at 15) that the Press Register "may" have violated ERISA's disclosure requirements by failing to provide Mr. Menton with a "sufficiently accurate and comprehensive" summary plan description and a copy of the HealthAmerica plan itself. However, the record clearly reflects that no violation of ERISA's disclosure requirements occurred. Assuming the Press Register was the "administrator" of the plan, ERISA does not require administrators to provide a summary plan description until ***after*** an employee becomes a participant in the plan. 29 U.S.C. § 1024(b)(1)(A). Hence, the Press Register was not obliged to provide Mr. Menton with a summary plan description until after he enrolled in HealthAmerica's plan.[11] Moreover, Mr. Menton did not contend that the Press Register provided an inaccurate

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[11] For this reason, both *Rodriguez v. MEBA Pension Trust*, 872 F.2d 69 (4th Cir. 1989) and *Davis v. Liberty Mut. Ins. Co.*, 871 F.2d 1134 (D.C. Cir. 1989), cited by petitioners (Pet. at 15), are inapplicable. Both cases involve failure to supply the employee with a summary plan description *after* he became a participant.

summary plan description.[12] Furthermore, ERISA requires administrators to provide participants with a copy of the actual plan instrument only "upon ***written request***" of a plan participant. 29 U.S.C. § 1024(b)(4) (emphasis added). It is undisputed that Mr. Menton did not request, in writing or otherwise, a copy of the plan instrument. Hence, ERISA's disclosure requirements were not violated under the facts of the instant case.

Petitioners also contend that Mr. Menton may have a claim for breach of fiduciary duty. To reach this conclusion, petitioners *assume* that Merle was, in fact, a fiduciary. There is no evidence to support this assumption in the record. ERISA defines the term fiduciary as follows:

> "[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or

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[12] In three of the cases cited by the petitioners, the plaintiffs specifically alleged that the summary plan description was inaccurate or materially different from the terms of the plan instrument. *Edwards v. State Farm Mut. Auto. Ins. Co.*, 851 F.2d 134 (6th Cir. 1988); *McKnight v. Southern Life and Health Ins. Co.*, 758 F.2d 1566 (11th Cir. 1985); *Kochendorfer v. Rockdale Sash & Trim Co., Inc.*, 653 F. Supp. 612 (N.D. Ill. 1987). In *Genter v. Acme Scale & Supply Co.*, 776 F.2d 1180 (3rd Cir. 1985), the plaintiff alleged that the terms of the plan were contrary to the plan administrator's practice of allowing participants to increase life insurance benefits prior to the time specified in the plan. The instant case is clearly distinguishable.

> other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan."

29 U.S.C. § 1002(21)(A). There is no evidence that Merle possessed or exercised any discretionary authority or control over the management or administration of the plan or the disposition of its assets. To the contrary, Merle was simply a sales representative whose sole role was to solicit membership for HealthAmerica. As the court noted in *Berlin v. Michigan Bell Tel. Co.*, 858 F.2d 1154, 1160 (6th Cir. 1988), " 'before the court can determine whether a fiduciary violated his duties, the court must determine if he was acting as a fiduciary when he engaged in the disputed conduct.' " Even assuming Merle possessed some discretionary authority over the plan, she did not become a fiduciary with respect to Mr. Menton until after he became a participant in HealthAmerica's plan.[13]

Petitioners also suggest (Pet. at 17) that Mr. Menton "may" have failed to pursue formal grievance procedures. To support this contention, petitioners cite *Makar v. Health Care Corp. of Mid-Atl.*, 872 F.2d 80 (4th Cir. 1989). However, in *Makar*, the Plan removed the action to federal court and raised plaintiffs' failure to exhaust plan remedies as an affirmative defense. *Id.* at 82. In the

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[13] The cases cited by petitioners concern misrepresentations by fiduciaries to employees who were already participants in the plan. *Local Union 2134, United Mine Workers of America v. Powhatan Fuel*, 828 F.2d 710 (11th Cir. 1987); *Berlin v. Michigan Bell Tel. Co.*, 858 F.2d 1154 (6th Cir. 1988).

instant case, petitioners completely failed to raise this issue at any stage in these proceedings prior to the instant petition. Obviously, petitioners waived this defense.

ERISA's fiduciary and disclosure provisions have nothing whatsoever to do with the independent solicitation of plan membership, or other activities designed to induce employees to become members of a plan. ERISA does not speak to these activities because it was Congress' intent as expressed in the savings clause to preserve the regulation of these activities to the States. Any other holding would leave solicitation activities designed to induce employees to join employee benefit plans wholly unregulated by either ERISA or state law.

IV. THE COURT SHOULD NOT GRANT REVIEW IN THIS CASE TO DECIDE WHETHER THE DUE PROCESS CLAUSE LIMITS THE SIZE OF PUNITIVE DAMAGES AWARDS.

A. Petitioners' Failed to Timely and Properly Raise Any Federal Constitutional Challenges To The Size of the Punitive Damages Award

It is undisputed that petitioners did not raise any constitutional challenges to Alabama's process of awarding punitive damages until they filed motions for judgment notwithstanding the verdict and new trial, *twenty-nine days after the trial court had entered judgment on the jury's verdict*. App. at 25a. Under settled Alabama law, a party "cannot 'invoke action by a court and have a case tried on certain issues and then later, when dissatisfied with the result, raise an entirely new issue, such as the

constitutionality of the statutes under which he was proceeding, on motion for new trial.' " *Alabama Power Co. v. Capps*, 519 So. 2d 1328, 1330 (Ala. 1988), quoting, *Talley v. A&M Const. Co.*, 284 Ala. 371, 373, 225 So. 2d 359, 360 (1969), *cert. den.*, 397 U.S. 995 (1970). In Alabama, constitutional issues raised for the first time in a motion for judgment notwithstanding the verdict or new trial will not be considered on appeal. *Hicks v. Huggins*, 405 So. 2d 1324 (Ala. Civ. App.), *cert. denied*, 405 So. 2d 1328 (Ala. 1985); *Marion v. Hall*, 429 So. 2d 937 (Ala. 1983). For this reason, the Alabama Supreme Court correctly refused to consider petitioners' constitutional challenges. Opinion, Pet. at 25a.

Because the Alabama Supreme Court refused to review petitioners' constitutional challenges based upon valid, settled, Alabama procedural principles, this Court should follow its customary practice of refusing to grant review on questions not pressed or passed upon below. In *Bankers Life and Cas. Co. v. Crenshaw*, 100 L.Ed.2d 62 (1988), this Court noted that it declines to exercise its certiorari jurisdiction under circumstances such as in the instant case.

> "In determining whether to exercise jurisdiction over questions not properly raised below, the Court has focused on the policies that animate the 'not pressed or passed upon below' rule. These policies are first, comity to the States, and second, a constellation of practical considerations, chief among which is our own need for a properly developed record on appeal. See, *Webb v. Webb, supra*, at 500-501, 60 L.Ed.2d 392, 101 S.Ct. 1889. Because the chief issue appellant would have us resolve – whether the Eighth Amendment's Excessive Fines Clause serves to limit punitive damages in States' civil cases – is

> a question of some moment and difficulty, these policies apply with special force. See, *Illinois v. Gates, supra*, at 224, 76 L.Ed.2d 527, 103 S.Ct. 2317 ('where difficult issues of great public importance are involved, there are strong reasons to adhere scrupulously to the customary limitations on our discretion'); *Mishkin v. New York*, 383 U.S., at 512-513, 16 L.Ed.2d 56, 86 S.Ct. 958 ('The far-reaching and important questions tendered by this claim are not presented by the record with sufficient clarity to require or justify their decision')."

Id. at 72-73. The factors which led this Court to deny review of difficult constitutional issues in *Crenshaw* are present here. Petitioners have offered no compelling reason why the principles which led this Court to deny review in *Crenshaw* should not be followed in the instant case.

In the interest of comity, the Alabama Supreme Court has determined, as a matter of state law, that petitioners failed to timely raise any constitutional issues. Opinion, Pet. at 25a. Moreover, petitioners' failure to timely raise this issue below has resulted in the complete absence of a properly developed record. In the absence of such a record, the difficult constitutional questions proposed to be raised by petitioners would be made even more difficult.

B. Alabama Provides Substantial Standards and Procedures for Assessing and Reviewing Punitive Damages Awards

Petitioners do not here contend that the jury's verdict was the product of bias, passion, prejudice, corruption, or other improper motive, and the trial court found as a fact that it was not. Opinion, App. at 28a. Nor was the jury's

award the product of "unbridled and standardless" discretion. To the contrary, under recently augmented common law standards and procedures, jury discretion is constrained by very specific standards and instructions, and jury verdicts are subjected to searching post-trial review by trial and appellate courts to insure those verdicts are fair and reasonable. "If a defendant is dissatisfied with a jury's verdict, and feels that it is excessive, or otherwise flawed, he is entitled to the protection of a variety of safeguards." *Central Ala. Elec. Co-op. v. Tapley*, 546 So. 2d 371, 376 (Ala. 1989).

The Alabama Supreme Court has fashioned procedural and substantive safeguards to insure fair and consistent administration of punitive damages. Upon motion of a defendant, trial courts must hold *evidentiary hearings* and to provide written reasons for accepting or modifying a jury's verdict. *Hammond v. City of Gadsden*, 493 So. 2d 1374, 1378-79 (Ala. 1986); *Green Oil v. Hornsby*, 539 So. 2d 218, 223-24 (Ala. 1989). In deciding whether a particular award is excessive, the trial court is authorized to consider many factors, including the degree of reprehensibility of the defendant's conduct, defendant's awareness of the harm likely to be caused by his conduct and defendant's attempt to "cover-up" the wrongdoing. Trial courts are instructed that punitive damages should bear a reasonable relationship to the harm which was likely to occur from the defendant's conduct. *Hornsby* at 223-24; *Tapley* at 377. The defendant is permitted to present evidence to show that the jury's verdict is "unreasonable, disproportionate or economically destructive".

Industrial Chem. and Fiberglass Corp. v. Chandler, 547 So. 2d 812, 839 (Ala. 1988).[14]

The defendant may appeal "as a matter of right" from the trial court's denial of motions for remittitur or new trial and "is entitled to a *de novo* review of the jury's verdict on appeal." *Tapley*, 546 So. 2d at 376-77; Ala. Code § 12-22-71. Appellate courts are free to make their own independent assessment of the factual basis for the amount of the award, and can "order a new trial due to the excessiveness of the verdict", or can "order a new trial unless the plaintiff accepts a remittitur." *Id.* at 377 (citations omitted).

Petitioners had the benefit of all of these standards and procedures. The jury was properly instructed as to the law of punitive damages, including the admonition that the jury "must take into consideration the character and degree of the wrong as shown by the evidence in the case and the necessity of preventing similar wrongs in the future". After the jury's verdict, petitioners filed motions for judgment notwithstanding the verdict, a new trial and a remittitur. The trial court denied these motions and entered an order setting forth its reasons for finding that the award was not excessive. The trial court found that the "jury carefully and conscientiously followed the

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[14] "In sum 'fundamental fairness' requires that the defendant be given the opportunity to present proof to the trial court during post-judgment review of the verdict that the punitive award is unreasonable, disproportionate or economically destructive (the plaintiff, of course, is entitled to offer proof contradicting the defendant's, or, conversely, to offer proof that the award is inadequate)." *Industrial Chem.* at 839.

court's instructions in assessing damages in the case at $1,800,000.00" and that "there was clear and convincing evidence of fraud on the part of [petitioners], which in the Court's opinion fully justified the jury's verdict." Pet. at 49a. Petitioners appealed that decision as of right to the Alabama Supreme Court, which conducted a *de novo* review and affirmed the trial court in its entirety. Opinion, Pet. at 25a-28a.

Clearly, the unique post-judgment procedures afforded to and invoked by petitioners have protected them against any "arbitrary" action on the jury's part in awarding punitive damages. Accordingly, petitioners have been afforded all of the essentials of due process. *Browning-Ferris v. Kelco Disposal*, 106 L.Ed.2d 219, 242 (1989)(Brennan, J., concurring).

Petitioners have not cited any federal appellate cases which adopt the due process limitation on punitive damages they urge, because there are none.[15] To the contrary, courts that have addressed the issue have rejected any such due process limitations. *See, e.g., Miller v. Cudahy Co.*, 858 F.2d 1449, 1459 (10th Cir. 1988)("appellants have cited no persuasive federal constitutional authority to support their argument" [that the Fourteenth Amendment requires limits on award of punitive damages]), *cert. denied*, 109 S.Ct. 3265 (1989).

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[15] Petitioners do cite *Juzwin v. Amtorg Trading Corp.*, 705 F. Supp. 1053 (D.N.J. 1989). However, that court vacated its decision. 718 F. Supp. 1233. In any event, the court's due process ruling concerned "repetitive awards of punitive damages for the same conduct . . . ", 718 F. Supp. at 1234, which has not occurred in the instant case.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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